Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-09-7705-01
TEXAS HEALTH, LLC 5445 LA SIERRA DR. # 204 DALLAS, TX. 75231	
Respondent Name and Box #:	
MESQUITE ISD REP. BOX # 42	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "…The treatment that was provided is part of her compensable injury to her shoulder, neck and back that she sustained on 04/17/08. Also, CPT code 90806 was preauthorized…."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $605.89
3. CMS 1500s
4. EOBs
5. Pre-authorization letter
6. Medical records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: Not submitted to MDR.

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
7-22-08	90801 (x5 units/hours)	11 & 193	1,2,3,4,6,&7	$195.71
8-25-08 9-5-08 9-12-08	90806	11A & 193	1,2,3,4,6,&7	$345.18
9-12-08	96151 (x2 units)	11 & 193	1 & 5	$0.00
Total Due:				$540.89

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.203, titled *Medical Fee Guideline for Professional Services* effective for professional medical services provided on or after March 1, 2008, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason codes "11" (the diagnosis is inconsistent with the procedure), "193" (original payment decision is being maintained-upon review, it was determined that this claim was processed properly), and "11A" (the diagnosis is inconsistent with the procedure-*the Medicare Psychiatric Manual requires the diagnosis to be coded with the highest level of specificity-the primary diagnosis as listed in the med records is not the same as listed on the CMS 1500). Typed statement at the bottom of all EOBs: "all bills with a psychiatric procedure code must also have a psychiatric diagnosis code on the bill".
2. A review of the CMS 1500 forms identify that the Requestor billed with the diagnosis codes of 840.9 (sprain and strain of unspecified site of shoulder and upper arm), 726.10 (unspecified disorders of bursa and tendons in shoulder region), 847.2 (lumbar sprain and strain), and 847.0 (neck sprain and strain). The carrier contends that a psychiatric diagnosis code should have been billed since a psychiatric procedural CPT code was billed.
3. Pursuant to Rule 134.600 (p), CPT code 90801 (psychiatric interview/exam) does not require pre-authorization unless it is a repeat interview. The pre-authorization letter submitted, number AP145191; identifies that individual psychotherapy 1 time a week for 3 weeks did receive authorization; (90806) service date range from 8-1-08 thru 9-12-08. The diagnosis codes identified on the pre-authorization letter are 840.9 (sprain and strain of unspecified site of shoulder and upper arm), 726.10 (unspecified disorders of bursa and tendons in shoulder region), 847.2 (lumbar sprain and strain), and 847.0 (neck sprain and strain). The carrier contends that a psychiatric diagnosis code should have been billed since a psychiatric procedural CPT code was billed.
4. The Requestor billed and received pre-authorization utilizing the accepted, compensable body areas/diagnoses. In accordance with Rule 134.203, it is stated within the 'Psychiatric Manual-under General Coding Guidelines' that "the psychotherapy diagnosis must be present on any claim submitted and must be coded to the highest level of specificity for that date of service" and "when coding diagnoses, include the primary diagnosis or condition (e.g., depression) as well as secondary diagnoses or conditions (e.g., Alzheimer's) that most closely reflect the medical necessity of the billed service". This coding structure is only applicable to Medicare beneficiaries and their payors. The Division concludes that this structure has no practical application in the worker's compensation (W.C.) system as the injured workers are not 'Medicare beneficiaries'. Payment is recommended in accordance with Rule 134.203 (b) and (c) (1).
    - 90801: $52.83 divided by 38.087 = 1.387 x $149.71 =$207.66 (not a timed code; payable @ 1 unit only)
    - 90806: $52.83 divided by 38.087 = 1.387 x $93.10 =$129.14
    - $129.14 x 3 DOS =$387.42
5. In accordance with Rule 134.203 (b) (1), CPT code 96151 is a component procedure to CPT code 90806 billed on this same day and is not separately payable. Payment is not recommended for this CPT code.
6. Per review of Box 32 on the CMS-1500, zip code 75231 is located in Dallas County. The maximum reimbursement amount under Rule 134.203 (b) is determined by locality.
7. Per Rule 134.203 (h), "reimbursement shall be the least of the (1) MAR amount; (2) health care provider's usual and customary charge; or (3) fair and reasonable amount consistent with the standards of §134.1 of this." The lesser of these three amounts was: provider's usual and customary charge.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code, Rules 134.1, 134.203, 134.600
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $540.89 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

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ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	12-10-09 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.